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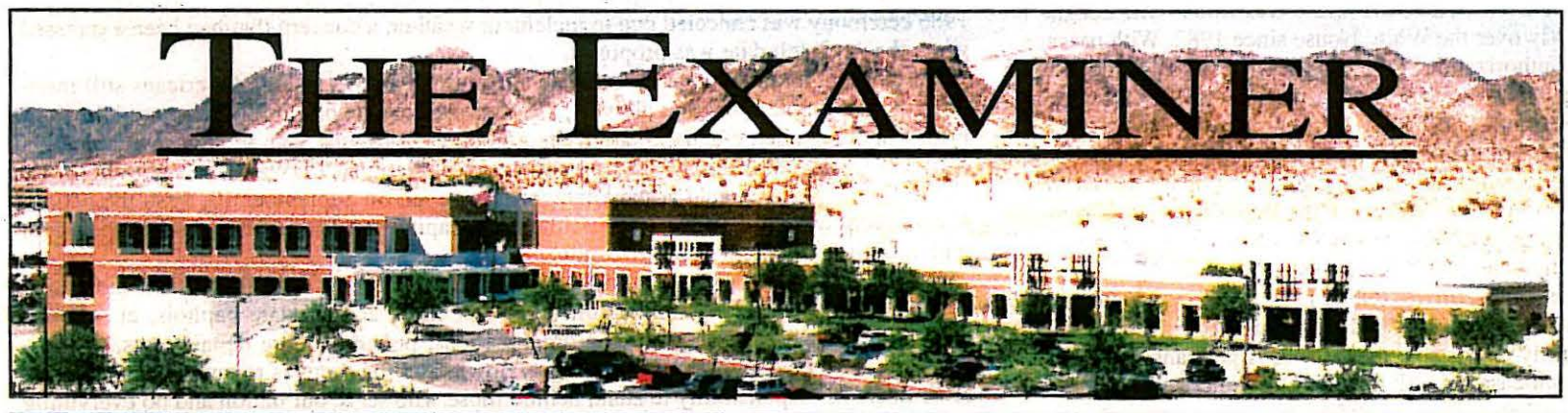
Robert E. Bush
Naval Hospital

Patriot's Day -- September 11, Terrorist attacks on World Trade Center and Pentagon Sept. 11, 2001

POW/MIA Recognition Day
September 16

Emergency Medicine named 23rd Medical Specialty on Sept. 21, 1979

THE EXAMINER



www.nhtp.med.navy.mil

Introducing the Director of Ambulatory Care

The Robert E. Bush Naval Hospital welcomes Captain Daniel Hansen, Medical Corps, United States Navy, as its newest Director of Ambulatory Care, replacing Commander Jay Erickson, who transferred to the 'greenside' last month.

Hansen hails from Lisbon, New Hampshire, where he attended Lisbon Regional High School, graduating Valedictorian in 1974. His curricular activities in his high school and community included Varsity soccer, skiing, basketball, and baseball; Drama Club; and he tutored and assisted with physical therapy of special education children.

He then went on to attend Bates College in Lewiston, Maine, where he earned his Bachelor of Science in Biology in 1978. He affiliated with the Navy June 15, 1977, after he was accepted to the Health Professions Scholarship Program.

Following his undergraduate study, Hansen attended Dartmouth Medical School in Hanover, New Hampshire, and graduated in 1981.

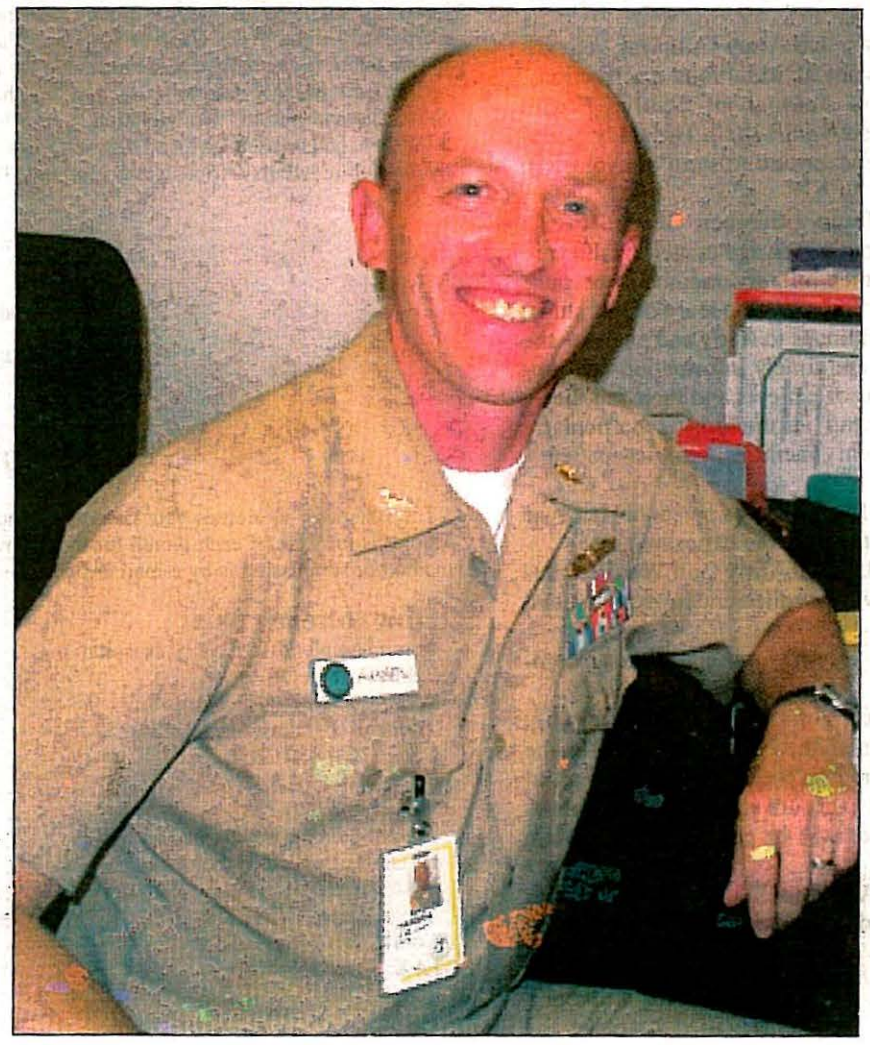
"I entered the Navy in 1977 in order to pay my way through medical school using the Health Professions Scholarship funds. Soon after putting on my uniform, I realized that a career in Navy Medicine was right for me," said Hansen.

Hansen's most memorable experience in the Navy to date was a three-month Temporary Assigned Duty on a humanitarian mission, providing much-needed medical care to refugees from Haiti.

Hansen is married to Karen Hansen of Warsaw, Indiana. They have two teenaged children; Blake and Marla.

When not busy with work the captain enjoys home-schooling his children, hiking, and visiting national parks.

Hansen's leadership philosophy is to promote teamwork and the professional and personal growth of each person; then optimal performance will follow.



Inside...

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2005 National POW/MIA Recognition Day --September 16

By HM2 Dempsey L. Tomblin
Robert E. Bush Naval Hospital

On September 16th of this year, commemoration will be set aside to honor the commitment and the sacrifices made by our nation's Prisoners of War and those who are still Missing in Action, and their families.

National POW/MIA Recognition Day is one of the six days specified by law 36 USC 902 on which the black POW/MIA flag shall be flown over federal facilities and cemeteries, post offices and military installations.

The importance of the League's POW/MIA flag is to show continued loyalty, a constant reminder of the hardships of America's POW/MIAs. Other than "Old Glory", the League's POW/MIA flag is the only flag ever to fly over the White House since 1982. With passage of Section 1082 of the 1998 Defense Authorization Act during the first term of the 105th Congress, the League's POW/MIA flag will fly each year on Armed Forces Day, Memorial Day, Flag Day, Independence Day, National POW/MIA Recognition Day and Veterans Day on the grounds or in the public lobbies of major military installations as designated by the Secretary of the Defense, all Federal national cemeteries, the national Korean War Veterans Memorial, the National Vietnam Veterans Memorial, the White House, the United States Postal Service offices and at the official offices of the Secretaries of State, Defense and Veteran's Affairs, and Director of the Selective Service System.

On August 10, 1990, the 101st Congress passed U.S. Public Law 101-355, which recognized the League's POW/MIA flag and designated it "as the symbol of our Nation's concern and commitment to resolving as fully as possible the fates of Americans still prisoner, missing and unaccounted for in Southeast Asia, thus ending the uncertainty for their families and the Nation".

No commemoration was ever held to honor America's POW/MIAs, those returned and those still missing and unaccounted for from our nation's wars, until July 18, 1979. Resolutions were passed in the Congress and the national ceremony was held at the National Cathedral, Washington, D.C. The Missing Man formation was flown by the 1st Tactical Squadron, Langley AFB, Virginia. The Veterans Administration published a poster including only the letters "POW/MIA" and that format was continued until 1982, when a black and white drawing of a POW in harsh captivity was used to convey the urgency of situation and the priority that President Ronald Reagan assigned to achieving the fullest possible accounting for Americans still missing from the Vietnam War.

The 1984 National POW/MIA Recognition Day ceremony was held at the White House, hosted by President Ronald Reagan. The Reagan Administration balanced the focus to honor all returned POWs and renew national commitment to accounting as fully as possible for those still missing. Perhaps the most impressive Missing Man formation ever flown was that year, up the Ellipse and over the White House. Unfortunately, the 1985 ceremony was canceled due to inclement weather, a concern that had been expressed when the April 9th date was proposed.

Therefore, in an effort to accommodate all returned POWs and all Americans still missing and unaccounted for from all wars, the National League of Families proposed the third Friday in September, a date not associated with any particular war and not in conjunction with any organization's national convention. Most National POW/MIA Recognition Day ceremonies have been held at the Pentagon. However, on September 19, 1986 the national ceremony was held on the steps on the U.S. Capitol facing the Mall, again concluding with a flight in Missing Man formation.

National POW/MIA Recognition Day Ceremonies are now held throughout the nation and around the world on military installations, ships at sea, state capitols, at schools, churches, national veteran and civic organizations, police and fire departments, fire stations, etc. The League's POW/MIA flag is flown, and the focus is to ensure that America remembers its responsibility to stand behind those who serve our nation and do everything possible to account for those who do not return.

Low-Level Exposure to Sarin Nerve Agent Study Released

In August, 2005, a study, "Mortality in US Army Gulf War Veterans Exposed to 1991 Khamisiyah Chemical Munitions Destruction," was published in the American Journal of Public Health (http://www.ajph.org/cgi/content/abstract/95/8/1382). The study evaluated potential mortality from low-level exposure to sarin or cyclosarin nerve agents.

Rear Admiral John M. Mateczus, Deputy Surgeon General of the Bureau of Medicine and Surgery sent out a message to alert health care providers as well as current and former military members, because health questions may arise in Gulf War veterans who learn of this study.

According to the Admiral, as DoD continues to study and evaluate the health of Gulf War veterans, accurate and timely information can provide answers and alleviate the concerns of patients and their families.

The Admiral added, that the following information is particularly important to Navy Military Treatment Facilities and its patients, because:

* This study did not include Navy or Marine Corps personnel because none were reported to be operating in the possible exposure area.

* This large cohort study involving 350,000 Army Gulf War Veterans concluded that All-Cause Mortality was no different in exposed and non-exposed personnel.

* Both study groups demonstrated a very low mortality rate as compared to the U.S. population.

* The study analyzed 60 separate causes of mortality. Only mortality resulting from solid brain tumors was slightly more common in the exposed group. †This finding should be interpreted with caution as, at this time, any link between nerve agent exposure and solid brain tumors has not been proven and further studies will be conducted to explore this association.

The Department of Defense (Health Affairs) will be sending letters to veterans/service-members who were identified as potentially exposed to very low levels of chemical warfare agent resulting after the demoli

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The Examiner welcomes your comments and suggestions concerning the publication. Deadline for submission of articles is the 15th of each month for the following month's edition. Any format is welcome, however, the preferred method of submission is by e-mail or by computer disk.

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Emergency Medicine Specialists Celebrate 26th Anniversary

This fall marks the specialty of emergency medicine's 26th anniversary. In only a quarter of a century, the specialty has come a long way.

Today, more than 114 million people seek care in the nation's emergency departments annually, making the emergency department America's health care safety net. Available 24 hours a day, 7 days a week, emergency physicians and nurses treat patients from all walks of life rich and poor, young and old, insured and uninsured.

The history of the American College of Emergency Physicians (ACEP) is forever linked with the development of the specialty. Founded in 1968, ACEP worked to establish standards for educating and training emergency physicians, and developing a board certification exam, which it achieved by 1975.

These accomplishments led to the American Medical Association's recognition of emergency medicine as the 23rd medical specialty in 1979, and to the establishment of 132 fully accredited emergency medicine residency programs and 30 osteopathic emergency medicine programs in the United States today.

Origins of the Specialty

During the conflicts in Korea and Vietnam, physicians practicing on the "home front" recognized that procedures and techniques developed for the battlefield could also be used in local hospitals to help save the lives of thousands of Americans each year. They saw the need for timely triage and the importance of beginning treatment in the crucial first minutes after an injury or onset of illness. Despite these medical advancements, even as late as the mid 1960s, emergency care in the United States was at best inconsistent. Inadequately equipped emergency 'rooms,' frequently staffed only by non-specialized nurses along with interns or on-

Continued on page 5.

Medical Minute...

Plastic Surgery for Military Beneficiaries

Lt. Catherine O. Durham, MSN, FNP
Robert E. Bush Naval Hospital

Many times throughout the week our medical providers are asked about plastic surgery. This is a very 'hot topic' socially, and medically. The purpose the article this month is to dispel some myths and answer some of the questions we are frequently asked.

Questions and Answers

Q 1: Just what is cosmetic surgery? Reconstructive surgery?

A 1: Cosmetic surgery is surgery performed to improve the appearance of someone who would otherwise be considered normal for age, race, etc. Reconstructive surgery restores to normal the function and or appearance of an abnormal part of the body, whether the defect is from trauma, cancer, congenital deformity, etc. Reconstructive surgery often requires the use of cosmetic surgery techniques to improve appearances of service members who are injured or disfigured as a result of combat, an accident or other conditions.

Q 2: Is it true that the military will perform 'makeovers' for anyone who is eligible for care from the military?

A 2: Military medicine is not in the 'makeover' business. However, military surgeons perform reconstructive surgery that often entails some degree of aesthetics. Experience with cosmetic cases gives the surgeons an ability to achieve the best possible results for reconstructive patients. Elective cosmetic surgeries occur on a space and time available basis; all beneficiaries except the active duty member pay for elective cosmetic surgeries.

Q 3: Are there cosmetic surgery centers in the military where beneficiaries go for their 'makeovers'?

A 3: The Department of Defense does not operate cosmetic surgery centers. However, some of the military hospitals have staff capable of performing reconstructive and cosmetic surgery procedures. Reconstructive surgery is performed by plastic surgeons, maxillofacial surgeons, ophthalmologists, and otolaryngologists. Not all military hospitals have the surgeons and support staff to perform reconstructive or cosmetic surgery.

Q 4: If someone wanted to have a procedure done and the military hospital where they lived does not offer it, can they go downtown and have TRICARE pay for it?

A 4: TRICARE will cover reconstructive, plastic and cosmetic surgeries under the following circumstances:

* Correction of a congenital anomaly (e.g., to correct a cleft palate)
* Restoration of body form following an accidental injury
* Revision of disfiguring and extensive scars resulting from cancer surgery
* Reconstructive breast surgery following a medically necessary mastectomy
* Penile implants for organic impotency and testicular prostheses
* Surgery determined to be a medically necessary procedure, integral to the restoration of an individual function
* Panniculectomy performed in conjunction with other abdominal or pelvic surgery when necessary to improve bodily function.

Q 5: Will TRICARE cover breast augmentations or face lifts?

A 5: No, some procedures that TRICARE will not cover include:

* Breast augmentation mammoplasty (except that post-mastectomy breast reconstruction may be covered)
* Face lifts and other procedures related to the aging process
* Blepharoplasty (except when performed for correction of documented significant impairment of vision)
* Rhinoplasties (except when performed to restore function)

Q 6: Does the military use cosmetic surgery as a recruiting incentive?

A 6: No, it is not the policy of the Department to offer cosmetic surgery as an inducement by recruiters to bring young men and women into the Armed Forces.

Q 7: Is there any good reason to do cosmetic surgery in the military?

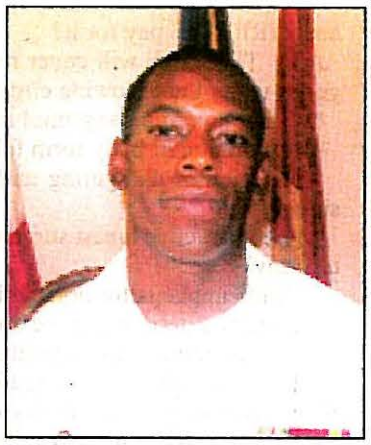
A 7: Military plastic surgeons, as with other specialists, require hours of education and training and continuous practice to keep their skill sets within medical standards. Without cosmetic surgery as part of their

Continued on page 7

Super Stars and Hard Chargers...

CSC Ernesto Borja, Nutrition Management Department, received a 3-6-9 Certificate for running a total of 300 miles.

Lt. Andrew Romelhardt, Pharmacist, received a 3-6-9 Certificate for running a total of 300 miles. At the same Awards ceremony, he also received a Navy Marine Corps Relief Society Certificate of Appreciation.



HM3 Melvin Dunson, of the Ortho/General Surgery Department, received his second Good Conduct Medal.

Lt. Cmdr. Candace Cornett, Physical Therapist, received a Navy and Marine Corps Commendation Medal.

Lt. j.g. Ayessa Fusilero, Head, Patient Administration, received a 3-6-9 Certificate for running a total of 600 miles.

HM3 Nicholas Jones, Occupational Health, received a Navy and Marine Corps Achievement Medal.

Lt. Brian Hower, Clinic Business Office, received a Navy and Marine Corps Commendation medal.

HN Stlaay Cloud-Morrison, Outpatient Administration, received a Meritorious Mast.

Lt. Sara Baldwin, Family Medicine Clinic, received a Navy and Marine Corps Commendation medal.

Lt. Cmdr. Laura Hamilton, Performance Improvement, Quality Assurance, departs the Naval Hospital upon her retirement from active duty. She stated that she is off to cooking school in Northern California.

Surgical Technologist Week Sept. 18 - 24

By Raymond Camp, NC
Peri-Operative Nurse
Robert E. Bush Naval Hospital

The Main Operating Room is celebrating National Surgical Technologist Week September 18-24. Please join us in recognizing our Surgical Technician's significant contribution to Navy Medicine.

Naval Hospital Twentynine Palms Surgical Technologists: HM2(SW) Maria Drew, HM3 Gabriella Aleman, HM3 Emily Martine, HM3 Oneika Flowers, HM3 Tiffany White, HM3 Meta Mitchell, HM3 Rhiannon Owens, HN Robin Taylor, HN Marcelo Pereira, HN Eric Willard, and HN Justin Jenkins.

The Surgical Technologist is responsible for three phases of patient care, or surgical case management, with minimal direction or supervision from their surgical team members. All surgical team members must adhere to the principles of asepsis and the practice of sterile technique. Honesty and moral integrity are necessary to uphold these standards.

The proficient Surgical Technologist must display a caring attitude toward the patient, other surgical team members, and the patient care environment. It is also necessary to understand normal anatomy and physiology, the pathological condition affecting the patient, the planned operative procedure, and consider any variations that may be necessary to accommodate a specific patient.

Before the operation, the Surgical Technologist prepares the OR by supplying it with the appropriate supplies and instruments. Other preoperative duties include adjusting and testing equipment, preparing the patient for surgery, and helping to connect surgical equipment and monitoring devices. The Surgical Technologist, usually the first member of the OR team to "scrub" and put on gown and gloves, prepares the sterile setup for the appropriate procedure and assists other members of the team with gowning and gloving.

During the operation, Surgical Technologists have primary responsibility for maintaining the sterile field. In order that sur-

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From left to right are, HM3 Emily Martine, HM3 Rhiannon Owens, HM3 Oneika Flowers, HM3 Tiffany White, HM3 Meta Mitchell, HN Eric Willard and HM2(SW) Maria Drew. Not pictured are HN Robin Taylor, HN Marcelo Pereira, HM3 Gabriela Aleman and HN Justin Jenkins.

Emergency Medicine Specialists...

Continued from page 3

call physicians, provided much of the care. Pre-hospital care was almost nonexistent, and medical treatment usually didn't begin until a patient arrived at the hospital.

As a result of the public's growing demand for access to medical services, emergency visits almost tripled between 1954 and 1964. The increased demand focused attention on improving emergency care.

In1966, the landmark report, Accidental Death and Disability: The Neglected Disease of Modern Society, described the deficiencies in the emergency care system and sparked public awareness of the importance of emergency medicine.

Emergency Physicians Today

Emergency physicians must have expertise in just about every other medical specialty. They see every kind of human drama imaginable, often treating multiple patients at a time. Some patients are desperately ill or severely injured and are engaged in an all-out fight for life. Other patients have less serious injuries and can be treated and released. Still others look to the emergency department to manage problems for which there are no medical cures, such as victims of gang violence or domestic abuse.

Today, if you have an emergency, you can expect to be cared for by highly trained emergency medicine specialists using the most advanced diagnostic equipment and the most effective medical techniques available. You don't have to look far to find those who are making a critical difference in our country's health care system today. They are the ones we count on to be on medicine's front line -- our emergency physicians.

Evolution of the Specialty

It became clear that emergency care required skills uniquely different from general medical practice, but there simply were no training programs for young doctors interested in practicing emergency medicine. However, on August 16, 1968, that began to change when a group of eight physicians who shared a commitment to improve the quality of emergency care met in Lansing, Michigan, to form the American College of Emergency Physicians. ACEP moved quickly to improve care by setting standards for educating and training emergency physicians.

In 1969, ACEP sponsored its first national meeting ó called Scientific Assembly now the premier annual forum in emergency medicine, presenting the most relevant, cutting-edge technologies and research, as well as discussions of the latest clinical controversies and critical policy issues.

By 1970, ACEP developed a curriculum for emergency medicine residency programs and instituted a program of continuing education. To achieve recognition as a specialty, ACEP in 1975 created a board-certification exam and promoted establishment of a certifying board.

Four years later, in September 1979, the American Medical Association and the American Board of Medical Specialties formally recognized emergency medicine as America's 23rd medical specialty and certification by the American Board of Emergency Medicine, which offered its first examination in 1980.

In 1985, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA), which mandated that all patients who come to emergency departments must be given a medical screening examination and be stabilized, regardless of ability to pay or insurance coverage. This regulation places great responsibility on emergency physicians to serve as the health care safety net for the nation's most vulnerable populations, including the uninsured.

Source: American College of Emergency Physicians Press Release

Make your move: TRICARE Moves with You

Changing duty stations can be hard, with packing and saying goodbye to friends, but TRICARE makes changing doctors and regions easy for the entire family, even TRICARE-eligible students leaving home for college.

TRICARE Prime benefits are portable. In other words, the TRICARE benefit is the same no matter where a beneficiary lives or travels within the Prime service area. When families transfer, travel or send a child off to college, TRICARE benefits are always available with no gaps in coverage.

This feature, which TRICARE calls 'portability,' eases the transfer for military families who are moving within the TRICARE West Region, administered by TriWest Healthcare Alliance, or to another TRICARE region.

Those moving outside their current TRICARE region should remain enrolled in that region until they arrive at their destination. Upon arrival at the new duty station, all they need to do is contact the local TRICARE Service Center to enroll in the new region and select a new primary care manager. The regional TRICARE contractors will coordinate the transfer, so enrollment will be effective as soon as the new contractor receives the application. In this way, Prime enrollment will be uninterrupted.

If TRICARE Prime is not available at the new location, beneficiaries may disenroll before moving and utilize the TRICARE Standard option (or TRICARE Extra by using only network providers). When they return to a Prime service area, they may reenroll in Prime at any time.

Prime portability is more limited for retirees than for active duty family members. Retirees and their eligible family members pay TRICARE Prime enrollment fees and may transfer their enrollment from one TRICARE region to another without paying additional enrollment fees. Although retired service members and their eligible family members are allowed unlimited moves within their own TRICARE region, they are limited to two moves between regions per year...as long as the second move brings them back to their original TRICARE region.

When a TRICARE-eligible son or daughter leaves home to attend college as a full-time student, TRICARE Prime's 'split enrollment' feature will enable students to stay enrolled in Prime. Split enrollment allows TRICARE Prime non-active duty families to live and enroll in different Prime service areas or TRICARE regions and to pay only one family fee per enrollment period.

For college students to take advantage of TRICARE Prime split enrollment, they must be

* enrolled in DEERS,
* under the age of 23,
* enrolled full-time in a program of higher learning as approved by the Secretary of Defense, the Department of Education or a state agency, and

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Surgical Technologist...

Continued from page 5

gery may proceed smoothly, they must assess and anticipate the needs of the patient and surgeon and provide the necessary items in order of need. As directed by the Surgeon, Surgical Technologists may sponge or suction the operative site, prepare suture material, dispense appropriate fluids and drugs, and prepare specimens for subsequent pathologic analysis.

After the operation, Surgical Technologists are responsible for applying dressings and preparing the OR for the next case.† Surgical Technicians deliver specimens to hospital laboratories for analysis, and after operations they take patients to the recovery room. They are also responsible for cleaning, maintaining, and sterilizing surgical instruments so they may be used for later surgeries. Additional duties and responsibilities of the Surgical Technologist are too numerous to mention.

Surgical Technologists serve at all Military Treatment Facilities, Hospital ships, Aircraft Carriers, Fleet Amphibious Assault Ships, Fleet Hospitals, Force Surgical Support Group, and Surgical Shock Trauma Platoons in support of the operational commitments of the U.S. Navy and U.S. Marine Corps. So take advantage of this occasion to congratulate the Hospital Corpsmen who are trained as Surgical Technologists as they celebrate their profession and their contribution to Navy Medicine. Any Corpsmen interested in the Surgical Technologist 'C' school please contact HM3(SW) Drew at 830-2311.

Hail and Farewell

Welcome Aboard

Lt. M. Guy
Lt. Cmdr. D. Burnell
Lt. R. Heninger
HM2 J. Pimentel
CSSN R. Collier
HN J. Torres
HN J. Atkinson
HN A. Wasson
HA S. Chong
HA J. Chiaia
HA P. Ramirez
HA T. Huyler
CSSR M. Decastro
CSSR A. Lee
HR S. Escalante
HR I. Shirota
HR B. Allen

Farewell

Lt. Cmdr. M. Alexander
CS3 K. Crisostomo

Plastic Surgery...

Continued from page 3

scope of practice many would see military service as onerously restrictive, depriving them of experience in a fundamental part of the plastic surgery field.

Q 8: If someone who wants a breast augmentation takes an assignment in Washington D.C., will that guarantee the procedure will be done?

A 8: No, there is no guarantee that a particular elective procedure will be performed. Elective procedures are done on a space available basis.

Q 9: What is the policy on coverage of cosmetic surgery?

A 9: The purpose of supporting plastic surgery in the military is to support graduate medical education, to allow surgeons to collect cases for board certification, and to maintain surgeons' skills.

Since the military services must retain specialists in the fields of plastic surgery, otolaryngology, ophthalmology, dermatology and oral surgery to accomplish both the wartime and peacetime missions, it is imperative to train residents and provide adequate skill maintenance for board certified physicians in these clinical areas.

* Residents and staff physicians in these specialties area able to perform limited numbers of cosmetic surgery procedures. For each procedure, the number of procedures is restricted to that number the typical civilian resident performs in a non-military training program, as reported by the Plastic Surgery Residency Review Committee.

* The specialty procedures are to be performed only by:

o residents in the specialties that require training in cosmetic surgery procedures as part of their graduate medical education programs (i.e., plastic surgery, otolaryngology, dermatology, and oral surgery)

o staff surgeons preparing for board certification

o staff certified in those specialties in order to maintain their skills and proficiency.

* The fee charged for elective procedures performed on dependents is based on the International Classification of Diseases ñ Clinical Modification (ICD-9CM) and Physicians Current Procedural Terminology (CPT 4). All non-active duty beneficiaries who have non-therapeutic cosmetic procedures must pre-pay the established daily rate or outpatient rate depending on the complexity of the procedure. These fees are set annually by the DoD Comptroller.

* The policy prohibits discrimination based on the rank of the sponsor in the selection of patients for such procedures.

Q 10: Is this for active duty only or are retirees and family members eligible for these services?

A 10: All beneficiaries are eligible. There is no discrimination based on the rank of the sponsor.

Q 11: For breast enlargements, - does the military remove/and or replace if there is a problem with leakage?

A 11: This is not a TRICARE benefit. If the current beneficiary had the procedure done in the private sector, the recommendation is for the beneficiary to seek this care in the private sector. However, if the procedure was done in the private sector and a decision is made to remove it at an MTF, a periprosthetic capsulotomy will carry a charge.

If the procedure is done in the MTF, the implant and procedures used for the augmentation mammaplasty is in full compliance with Food and Drug Administration guidelines. If the procedure was done as a breast reconstruction following surgery for cancer, and the device leaks, removal/replacement is a TRICARE benefit and there would be no charge in the Military Treatment Facility (MTF).

Q 12: Who pays for these services?

A 12: There is no charge for reconstructive surgery related to trauma, burns, or disease. Active duty members must purchase any cosmetic implants or supplies but pay no surgical fee. All others must pay a surgical fee. These fees, posted each year by the OSD Comptroller are similar to what a patient might pay in the private sector.

And finally, if you are interested in any surgical procedure contact your PCM to talk about the risks and benefits of surgery.

Coming Next Month: Breast Health Awareness.

Nerve Agent Study...

Continued from page 2

tion of munitions at Khamisiyah, Iraq.

According to Mateczus, no Navy or Marine Corps personnel are known to have been exposed, however, the Admiral wishes to make it clear that, perceptions of exposure or concerns must be addressed. For veterans no longer affiliated with the military, the Department of Veterans Affairs offers a medical evaluation program for Gulf War veterans. Those individuals can schedule an appointment by calling the VA's Gulf War helpline at 1-800-749-8387.

For further clarification or details, please contact Lt. Cmdr. Thomas C. Luke, MC, USN at 202-762-3496 or email at tcluke@us.med.navy.mil.

Advance Directives: What Are They and How Do I Get One?

By Lt. Richard Salsbury
Robert E. Bush Naval Hospital

Have you ever considered what would happen to you if you were suddenly rushed to the emergency room and unable to communicate to the attending hospital staff what type of procedures you did or did not want them to perform?

In such events as these, the physician usually questions the spouse or next of kin about the patient's preferences with regard to certain life-saving measures. However, these kinds of decisions should not be left to the moment of distress; it is far wiser to make your decisions while you are of sound mind and body, and furthermore, to make such decisions known.

An advance directive is a document stating your desires regarding various medical treatments and also designates another person whom you authorize to make additional medical decisions for you in the event that you are unable to speak for yourself. The following case illustrates the importance of obtaining such a directive...in advance.

Betty* (name changed for privacy), a 60-year-old female, was presented to the emergency room due to shortness of breath. Although she had had a long history of asthma, she had never needed to be intubated, a procedure where a device is inserted into the mouth in order to assist the patient in filling the lungs with oxygen. Upon admission, the intern spoke with her about 'code status,' specifically, what the hospital staff should do in the event that her heart stopped beating. Betty informed the intern that she "would not want to be on a tube to breathe." When asked about CPR, she stated, "I don't want shocks to the heart or pressing on my heart." She continued by telling the intern that if she could not live independently, she would rather not survive.

Understanding these statements to indicate her desire for DNR, Do Not Resuscitate, the intern then contacted the resident doctor to discuss her wishes, though neither staff member completed the hospital's DNR form. A few hours after her admission to the ER, the patient suffered sudden respiratory failure which lead to her heart stopping. The nursing staff initiated a code blue and successfully resuscitated and stabilized her. Fortunately for Betty, due to a lapse in the necessary paperwork, her wishes had not been made aware to the staff until after the fact.

In this case, the patient had not taken the time to discuss with her primary doctor her wishes about resuscitation. By addressing the issues of intubation and resuscitation, she could have gained greater understanding of the procedures and had particular myths dispelled. For example, she would have learned that in many cases of respiratory failure in asthmatics, intubation for a short time may return the patient to his/her previous level of health. Furthermore, she would have come to realize that intubation can be utilized as a temporary measure and is not synonymous with permanent respiratory support just as procedures used to "keep the patient alive" does not imply "in a vegetative state." It is precisely these types of questions and concerns that should be discussed with your doctor while you are in good health.

The Patient Admissions department at Naval Hospital Twentynine Palms can provide you with detailed information about advance directives as well as the forms themselves. You will need to provide the following information on your advance directive form:

1. Identification of an agent (someone who is willing to carry out your wishes);
2. Your specific directions with regard to withholding or withdrawing life-sustaining treatment;
3. Your intentions for organ donation;
4. Identification of the physician who is to have primary responsibility for your healthcare.

The form must be signed by two witnesses, both of whom cannot be hospital staff members or someone directly mentioned in your will or a potential beneficiary to any part of your estate. Finally, after you take the time to responsibly generate your advance directive, take the next step; establish a means by which to have the form accompany you to the hospital in the event that you become ill, and discuss your stated wishes, beforehand, with your loved ones.

Make Your Move...

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* at least 50-percent financially dependent on a TRICARE-eligible sponsor.

TRICARE-eligible college students may use military treatment facilities on a space-available basis, use civilian providers under TRICARE Standard or Extra, or be allowed to remain enrolled in TRICARE Prime. They may remain in Prime if the college or university they attend is located in a Prime service area.

To learn more about TRICARE Prime portability and split enrollment, visit the TriWest Healthcare Alliance web site at www.triwest.com or the TRICARE Management Activity (TMA) site at www.tricare.osd.mil. TMA's web site also shows which TRICARE contractor provides services in the area where your PCS will take you or where your student goes to college.